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EDITORIAL

Medicare and Medi-Cal

NOW THAT TEN MONTHS have passed since Medi-Cal and six months since Medicare became effective, it is appropriate to review and comment on the experiences of California physicians with these new laws. Considered the outstanding events in Medicine in 1966 the changes initiated by these statutes vitally affect all practicing physicians.

Medicare

From 1 July through 30 November 1966, the two Blue Cross plans in California had received almost 160,000 claims from hospitals and paid out nearly $60 million. The regulations have been modified so that one signature by the patient is now sufficient to support all claims for required services in a hospital. This requirement, we are told, has speeded up the processing of claims. The Blue Cross plans are further recommending that the requirement for the signature of a patient should be eliminated altogether, since it is often difficult for the hospital to obtain a signature, particularly in out-patient cases. The regulations have already been modified so that the Social Security Administration will now accept the signature of a relative, or even of a hospital official, if the patient is too ill to sign or has died.

Major problems that remain are caused by the complexity of the Medicare benefits. The beneficiaries do not understand to what they are and to what they are not entitled. Hospitals have found that billing for outpatient benefits under the law is most complicated.

By the first week in December 1966, California Blue Shield (CPS) had received a total of over 720,000 Part B Medicare claims and had paid out almost $7 million.

A substantial number of claim forms must still be returned for further information before they can be processed, resulting in an estimated backlog of approximately 140,000 claims over and above the normal number that are in the process of being paid.

Approximately 300,000 of the Medicare claims received by California Blue Shield through November 1966 were for patients who are eligible for both Medicare and Medi-Cal benefits. These "dual coverage" claims must be processed under the Medicare audit before they can be processed for Medi-Cal payment. This delay in processing and payment is, of course, a cause of considerable concern to many physicians and other providers of service. It is hoped that in the near future the law can be amended so that such claims need only be audited once and then paid with one check, issued either by the Social Security Administration or the State, rather than by two as at present. To do this it would be necessary for the two entities of government—federal and state—to make possible a bookkeeping or accounting record and credit of the proper amounts disbursed under both programs. This solution would be welcomed both by physicians and the carriers.

Medi-Cal

From 1 March through 30 November 1966, the Blue Cross plans processed more than 900,000

Medi-Cal claims. A breakdown of these claims by type of institution is as follows:

County hospitals	291,937
Community hospitals	338,694
Nursing homes	253,508
Mental and rehabilitation facilities	18,508
Home health agencies	23,556

Of the claims received, more than 83,000 were to be returned for revision or recheck. As the program matures, the number of claims that need to be returned will decrease. About $138 million was paid for claims that have been audited. In addition, claims totaling over $27 million for county hospitals were audited but not paid.

From March through November 1966, Blue Shield received nine and a half million claims, of which more than eight million had been paid and a total of over $98 million has been paid to physicians, dentists, pharmacists, podiatrists, optometrists, chiropractors and others under the program.

The four claimant categories were as follows:

	Claims Received	*Claims Paid*	*Total Amount Paid*
Physicians	2,558,813	2,014,460	$48,471,155
Other medical	680,603	533,992	12,373,365
Dental	373,540	277,626	16,917,682
Drugs	5,961,560	5,196,762	20,310,094

During November, 70 per cent payments were sent out on approximately one-half million claims for which eligibility had not been certified. The purpose of the 70 per cent payment was to relieve physicians and others of the financial burden imposed by the previous inability of Blue Shield to pay uncertified claims. When these partial payments were made, the physicians and others were sent a list of the claims in question.

Each physician was asked to check the data on the claim for accuracy and to correct it if necessary. When the correct information is returned to Blue Shield, eligibility of the claim will again be checked. When eligibility is verified, the balance of the payment will be made.

In the future, claims which cannot be matched against the eligibility file within 30 days after they are received will be returned to the physician or other provider so that such a backlog of unmatched claims will not again accumulate. All physicians and their office assistants should exercise great care in recording correct names, dates of eligibility, case numbers and aid categories in order to speed up verification by Blue Shield.

The former and present administrators of the program expressed deep concern about the total estimated cost of the program during the first fiscal year, which will end 30 June 1967. The following unexpected and unforeseen increases are causing major concern:

1. A substantial increase in the number of persons receiving nursing home care.
2. Substantial increases in the per diem cost of hospital and nursing home care.
3. The unknown and unresolved costs of physicians' services in county and teaching hospitals.
4. The unknown State cost of any increase in the medical care costs of counties for care rendered to persons in county hospitals.

It has been estimated that the cost of the program may overrun its budget by fifty million dollars. However, there are other estimates that the program will stay within its budgetary allowances.

Both the former and present administrators recommended that additional safeguards be placed upon nursing home utilization in order that the program can be made more financially stable. He felt that the program benefits and utilization should be carefully watched and controlled rather than that rates of compensation be decreased. We commend this approach and hope that the new administrator of the program will continue to support this comprehensive, high quality medical care program.

New Extended Care Benefits Under Medicare

Extended care benefits under Medicare for covered persons 65 and over became effective 1 January 1967. Under them a person may be admitted to a participating extended care facility for further treatment of a condition for which he was put in hospital. The hospital benefits under Part A of Medicare will pay for the full cost of covered services for the first 20 days and all but $5 per day for 80 additional days in each "spell of illness." Within each spell of illness the hospital benefits cover up to 90 days of hospital care and 100 days of extended care services.

The extended care service contemplated is distinct from acute hospital care on one hand, and on the other it is distinct from long-term care in a nursing home or home for the aged. It has been estimated that this Medicare benefit will not pay for more than one-fourth of the skilled nursing home beds in the country at any one time. It is not expected that all homes which have been consid-

ered skilled nursing homes will qualify and be certified as eligible for payment under the Medicare program.

Some problems need to be overcome to attain the potentialities of high quality extended care services. There are shortages of health personnel and obsolescence of equipment in some communities. Probably most of the facilities which will qualify in the early days of the program will be closely associated with hospitals.

There appears to be a need for and a challenge to physicians to become interested and involved in the growing development of high quality extended care facilities, in order that patients will receive the best possible care at the most economical rate within reason. Medical records in such facilities will receive more attention than in the past and medical committees will review the care rendered and the utilization patterns. This will not all happen overnight but there will surely evolve a broadening of a new level of care to be integrated with acute hospital care.